ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Lauren Daniels, a licensed acupuncturist.

I understand that methods of treatment may include but are not limited to acupuncture moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), and Gua Sha.

I have had the opportunity to discuss with the above named acupuncturist the nature and the purpose of acupuncture treatments and other procedures.

I have been informed that the acupuncture is safe method of treatment, but that I have some side effects, including bruising numbness or tingling near the needle sites that may last a few days, and dizziness or fainting. Bruising is a common side effects of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including long puncture (pneumothorax). I understand that the risk of infection is negligible when all needles are sterile.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is the in my best interest.

I understand the clinical and administrative staff may review my patient records and lab reports, but all records will be kept confidential and will not be released without my written consent.

I have read or have had read to me, the above consent to treatment, have been told about the risk and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

In accordance with 45:2C-5 the Standards governing practice of acupuncture. An acupuncturist shall advise each patient as to the importance of consulting with a licensed physician regarding the patient's condition.

PRINTED NAME:_____

PATIENT SIGNATURE:_____ DATE: _____
(Or Patient Representative)

This Information is Confidential

Personal Information Date: _____

Patient Name: _____ Referred By: _____

Address: _____

Home Number: _____ Cell _____ Email: _____

Date of Birth: _____ Height: _____ Weight: _____ Marital Status (M/S/D): _____

Occupation: _____ Physician name/phone number: _____

Emergency Contact Name/Phone Number: _____

Allergies (if applicable): _____

Have you ever had acupuncture before? _____

Medical History

What is the problem or problems which brings you here today? _____

_____

Physician's Diagnosis (if applicable): _____

When did this problem first appear? _____

Is it constant, or does it come and go? _____

If applicable, does the problem stay in one place or does it move? _____

Has there been anything which has been able to change this problem in any way? _____

What makes it better? (Circle any that apply): Heat | Massage | Cold | Movement | Pressure | Rest

Other: _____

What makes it worse? _____

Are you experiencing pain? _____

If so, rate your pain on a scale of 1 to 10, where 1 is the least and 10 is the worst: _____

If possible, describe the pain (i.e.: sharp, dull, burning, numb, aching, etc): _____

Are there any other problems you would like to address today? _____

Medicines (Please Circle any of the following that you are now taking):

Aspirin | Ibuprofen | Antacid | Oral Contraceptive | Diet Pills | Laxative | Tranquilizer

Sleeping Pills | Hay Fever Tablets | Cold Tablets | Vitamins | Herbs

Please list the names of any medication/herbs you are currently taking: _____

_____

Have you had any surgeries? Please list, include dates: _____

_____

History of Significant Illness/Injuries, include dates: _____

Self: _____

Mother: _____

Father: _____

Do you smoke? _____ If yes, how many cigarettes or packs/day? _____

Do you drink alcohol? _____ If yes, how many servings/week? _____

Do you drink coffee/caffeinated teas? _____ If yes, how many cups a day? _____

How is your sleep? (Any difficulties in falling asleep and staying sleep) _____

Do you have a bowel movement every day? _____

How would you rate your appetite? (Circle One)

LOW MODERATE EXCESSIVE

How would you rate your thirst? (Circle One)

LOW MODERATE EXCESSIVE

Do you regularly exercise? If so, describe: _____

How would you rate your energy level? (Circle One)

EXCELLENT GOOD FAIR POOR OTHER

How would you rate your feeling of emotional wellbeing? (Circle One)

EXCELLENT GOOD FAIR POOR OTHER

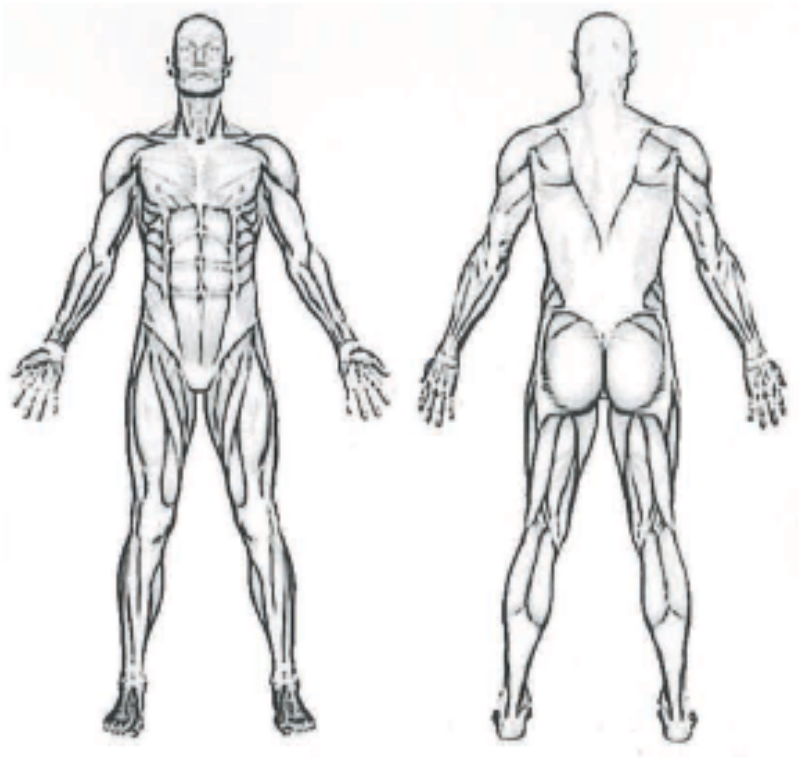
If applicable, describe any emotional challenges or concerns: _____

_____

Please mark to indicate if you have had any of the following:

AIDS/HIV ☐	Goiter ☐	Pacemaker ☐
Alcoholism ☐	Gonorrhea ☐	Parkinson's Disease ☐
Allergy Shots ☐	Gout ☐	Pinched Nerve ☐
Anemia ☐	Heart Disease ☐	Pneumonia ☐
Anorexia ☐	Hypertension ☐	Polio ☐
Appendicitis ☐	Hepatitis ☐	Prostate Problem ☐
Arthritis ☐	Hernia ☐	Psychiatric Care ☐
Asthma ☐	Herniated Disk ☐	Rheumatoid Arthritis ☐
Bleeding Disorders ☐	Herpes ☐	Rheumatic Fever ☐
Breast Lump ☐	High Cholesterol ☐	Scarlet Fever ☐
Bronchitis ☐	Kidney Disease ☐	Stroke ☐
Bulimia ☐	Liver Disease ☐	Suicide Attempt ☐
Cancer ☐	Lyme Disease ☐	Thyroid Problems ☐
Cataracts ☐	Measles ☐	Tonsillitis ☐
Chemical Dependency ☐	Migraine Headaches ☐	Tuberculosis ☐
Chicken Pox ☐	Miscarriage ☐	Ulcers ☐
Diabetes ☐	Mononucleosis ☐	Vaginal Infections ☐
Emphysema ☐	Multiple Sclerosis ☐	Whooping Cough ☐
Epilepsy ☐	Mumps ☐	Other _____ ☐
Glaucoma ☐	Osteoporosis ☐	

Mark an **X** on the picture where you have pain.



Acupuncture Re-scheduling Policy

At Fischer Health and Rehab we understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few of the reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients, and out of consideration for our acupuncturists' time, we have adopted the following policy:

24 hours' notice is required to cancel or reschedule an appointment. Failure to cancel appointments at least 24 hours in advance or failure to show up for your appointment will result in a charge of 50% of the scheduled appointment fee.

By signing this form, you acknowledge our policy and agree to the terms:

Name: _____ Date: _____

413 King George Road, Suite 205 | Basking Ridge, NJ 07920 | Phone: 908.903.1901 | Fax: 908.903.1902

WOMEN ONLY

Is there any chance you could be pregnant? _____

Total Pregnancies: _____

_____ # Living _____ # Ectopic _____ # Miscarriages _____ # Induced Abortions _____ # Multiple Pregnancies

Age menarche began: _____ Age menopause: _____ Day of last OB/GYN Exam: _____

Hysterectomy: Partial Full Hormone Replacement Therapy

Headaches: Before Menstrual Cycle During Cycle After Cycle

How many days of flow? _____ How many days between the period? _____

Please check any signs and symptoms that you have experienced during your period:

☐ Irregular Painful	☐ Heavy Flow	☐ Scanty Flow	☐ Dark Color Flow
☐ Light Color Flow	☐ Clotting	☐ Water Retention	☐ Abdominal Bloating
☐ Breast Lumps	☐ Emotional Changes	☐ Backache	☐ Painful or Tender Breasts
☐ Tightness in Chest	☐ Sign a lot	☐ Constipation and/or diarrhea	☐ Spotting between periods

Vaginal Discharges:

☐ Yellow ☐ Thick ☐ White ☐ Bad Odor ☐ Other: _____

FISCHER HEALTH & REHAB HIPPA COMPLIANT FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Fischer Health & Rehab we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or maybe responsible for the payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

If we provide health care services to you in an emergency; If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so; If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. If we are ordered by the courts or another appropriate agency;

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form, please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have any concerns, or would like further information about our privacy policies and practices please contact Dr. David Fischer. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. Your authorization is requested for purposes of delivering your care in an open-adjusting or open-door adjusting environment as described in the office's privacy notice. In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

My signature acknowledges that I have received a copy of this notice.

Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party

Personal Representative Printed	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient